PASSPORT Tips

- View the client's Medicaid ID card at each visit, or verify eligibility using one of the methods described in the *Client Eligibility and Responsibilities* chapter of the *General Information For Providers* manual.
- Do not bill for case management fees; they are paid automatically to the provider each month.
- If you are not your client's PASSPORT provider, include the PASSPORT provider's PASSPORT approval number on the claim, or it will be denied.
- The same cost sharing, service limits, and provider payment rules apply to PASSPORT and non-PASSPORT clients and services.
- For claims questions, refer to the *Billing Procedures* chapter in this manual, or call Provider Relations (see *Key Contacts*).

Prior Authorization

Some services require prior authorization (PA) before providing them. When seeking PA, keep in mind the following:

- The referring provider should initiate all authorization requests.
- Always refer to the current Medicaid fee schedule for PA requirements on specific services.
- The following table (*PA Criteria for Specific Services*) lists services that require PA, who to contact, and specific documentation requirements.
- For a list of prescription drugs that require PA, see the *PA Criteria for Prescription Drugs* table later in this chapter.
- Have all required documentation included in the packet before submitting a request for PA (see the following *PA Criteria for Specific Services* table for documentation requirements).
- When PA is granted by the Surveillance/Utilization Review Section, providers will receive notification from both the Quality Assurance Divison and the Claims Processing Unit. The *Prior Authorization Notice* from the Claims Processing Unit will have a PA number. This PA number must be included in field 23 on the CMS-1500 claim form.

PA Criteria for Specific Services

Service	PA Contact	Documentation Requirements

• **All out-of-state hospital care**
• **All transplant services**
• **All in-state and out-of-state rehab services**
	Mountain-Pacific Quality Health Foundation
	3404 Cooney Drive
	Helena, MT 59602
	
	Phone:
	(406) 443-4020 X150 Helena
	(800) 262-1545 X150 In and out of state
	Fax:
	(406) 443-4585 Helena
	(800) 497-8235 In and out of state
		• Required information includes:
		  • Client's name
		  • Client's Medicaid ID number
		  • State and hospital where client is going
		  • Documentation that supports medical necessity. This varies based on circumstances. Mountain-Pacific Quality Health Foundation will instruct providers on required documentation on a case-by-case basis.
		• Emergency out-of-state services must be reported within two business days of admission. For example, a client admitted on Sunday must report admission by Wednesday.

• **Transportation (commercial and scheduled ambulance transport)**
 	
(For emergency ambulance transport services, providers have 30 days following the service to obtain authorization.)
	Mountain-Pacific Quality Health Foundation
	Medicaid Transportation
	P.O. Box 6488
	Helena, MT 59604
	
	Phone:
	(800) 292-7114
	Fax:
	(800) 291-7791
	E-Mail:
	ambulance@mpqhf.org
		• Ambulance providers may call, leave a message, fax, or E-mail requests.
		• Required information includes:
		  • Name of transportation provider
		  • Provider's Medicaid ID Number
		  • Client's name
		  • Client's Medicaid ID number
		  • Point of origin to the point of destination
		  • Date and time of transport
		  • Reason for transport
		  • Level of services to be provided during transport (e.g., BLS, ALS, mileage, oxygen, etc.)
		• Providers must submit the trip report and copy of the charges for review after transport.
		• For commercial or private vehicle transportation, clients call and leave a message, or fax travel requests prior to traveling.

• **Eye prosthesis** • **New technology codes (Category III CPT codes)** • **Other reviews referred by Medicaid program staff**	Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-2953 **Phone:** (406) 444-0190 Helena and out of state (406) 444-1441 Helena and out of state **Fax:** (406) 444-0778	• Documentation that supports medical necessity • Documentation regarding the client's ability to comply with any required after care • Letters of justification from referring physician • Documentation should be provided at least two weeks prior to the procedure date.

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements
• **Circumcision**	Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-2953 **Phone:** (406) 444-0190 Helena and out of state (406) 444-1441 Helena and out of state **Fax:** (406) 444-0778	• Circumcision requests are reviewed on a case-by-case basis based on medical necessity when one of the following occurs: • Client has scarring of the opening of the foreskin making it non-retractable (pathological phimosis). This is unusual before five years of age. The occurrence of phimosis must be treated with non-surgical methods (i.e., topical steroids) before circumcision is indicated. • Documented recurrent, troublesome episodes of infection beneath the foreskin (balanoposthitis) that does not respond to other non-invasive treatments and/or sufficient hygiene • Urinary obstruction • Urinary tract infections

• **Prophylactic Mastectomy**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-295
	
	Phone:
	(406) 444-0190 Helena and out of state
	(406) 444-1441 Helena and out of state
	Fax:
	(406) 444-0778
		• Prophylactic mastectomy is not a routinely covered benefit, but individual cases may be review for medical necessity. Factors that may considered for review include:
		  • Histology - Presence of lobular carcinoma in situ is a risk factor for development of cancer in either breast.
		  • Family history - Having more than one first degree relative who has had breast cancer, particularly when one had bilateral cancer.
		  • Age at the time of diagnosis. Recurrence is more likely with younger clients.
		  • Oncological consultation that supports the bilateral mastectomy.

• **Dispensing and fitting of contact lenses**	Provider Relations
	P.O. Box 4936
	Helena, MT 59604
	
	Phone:
	(406) 442-1837 Helena and out of state
	(800) 624-3958 In state
		• PA required for contact lenses and dispensing fees.
		• Diagnosis must be one of the following:
		  • Keratoconus
		  • Aphakia
		  • Visual acuity (must document correction with glasses and with contact lenses)

• **Prescription Drugs** (For a list of drugs that require PA, refer to the *PA Criteria for Prescription Drugs later in this chapter.*)	Drug Prior Authorization Unit Mountain-Pacific Quality Health Foundation 3404 Cooney Drive Helena, MT 59602 **Phone:** (406) 443-6002 Helena (800) 395-7961 In and out of state **Fax:** (406) 443-7014 Helena (800) 294-1350 In and out of state	• Refer to the *PA Criteria for Prescription Drugs* table in this chapter for a list of drugs that require PA. • Providers must submit the information requested on the *Request for Drug Prior Authorization Form* to the Drug Prior Authorization Unit. This form is in *Appendix A: Forms*. • The prescriber (physician, pharmacy, etc.) may submit requests by mail, telephone, or FAX to the address shown on the *PA Criteria for Specific Services* table.

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements

• **Reduction Mammo-plasty**	SURS
	P.O. Box 202953
	Helena, MT
	59620-2953
	
	Phone:
	(406) 444-0190
	Helena and out of state
	
	(406) 444-1441
	Helena and out of state
	
	Fax:
	(406) 444-0778
		• Both the Referring physician and the surgeon must submit documentation.
		• Back pain must have been documented and present for at least six months, and causes other than weight of breasts must have been excluded.
		• **Indications for female client:**
		• Contraindicated for pregnant women and lactating mothers. A client must wait six months after the cessation of breast feeding before requesting this procedure.
		• Female client 16 years or older with a body weight less than 1.2 times the ideal weight.
		• There must be severe, documented secondary effects of large breasts, unresponsive to standard medical therapy administered over at least a six month period. This must include at least two of the following conditions:
		  • Upper back, neck, shoulder pain that has been unresponsive to at least six months of documented and supervised physical therapy and strengthening exercises
		  • Paresthesia radiating into the arms. If parathesia is present, a nerve conduction study must be submitted.
		  • Chronic intertrigo (a superficial dermatitis) unresponsive to conservative measures such as absorbent material or topical antibiotic therapy. Document extent and duration of dermatological conditions requiring antimicrobial therapy.
		  • Significant shoulder grooving unresponsive to conservative management with proper use of appropriate foundation garments which spread the tension of the support and lift function evenly over the shoulder, neck and upper back.
		Documentation in the client's record must indicate and support the following:
		• History of the client's symptoms related to large, pendulous breasts.
		• The duration of the symptoms of at least six months and the lack of success of other therapeutic measures (e.g., documented weight loss programs with six months of food and calorie intake diary, medications for back/neck pain, etc.).
		• Guidelines for the anticipated weight of breast tissue removed from each breast related to the client's height (which must be documented):
		Height — **Weight of tissue per breast**
		less than 5 feet — 250 grams
		5 feet to 5 feet, 2 inches — 350 grams
		5 feet, 2 inches to 5 feet, 4 inches — 450 grams
		greater than 5 feet, 4 inches — 500 grams
		• Pre-operative photographs of the pectoral girdle showing changes related to macromastia.
		• Medication use history. Breast enlargements may be caused by various medications (e.g., sironolactone, cimetidine) or illicit drug abuse (e.g., marijuana, heroin, steroids). Although rare in women, drug effects should be considered as causes of breast enlargement prior to surgical treatment since the problem may recur after the surgery if the drugs are continued. Increased prolactin levels can cause breast enlargement (rare). Liver disease, adrenal or pituitary tumors may also cause breast enlargement and should also be considered prior to surgery.
		• **Indications for male client:**
		• If the condition persists, a client may be considered a good candidate for surgery. Clients who are alcoholic, illicit drug abusers (e.g., steroids, heroin, marijuana) or overweight are not good candidates for the reduction procedure until they attempt to correct their medical problem first.
		• Documentation required: length of time gynecomastia has been present, height, weight, and age of the client, pre-operative photographs

PA Criteria for Prescription Drugs

Drug	Criteria
Non-steroidal Anti-Inflammatory Drugs PA required for all single-source NSAIDS: Ponstel Relaten Mobic Naprelan	Trial and failure with at least <u>two</u> multiple-source products must be documented.
Celebrex (celecoxib) Vioxx (rofecoxib) Bextra (valdecoxib)	No history of aspirin sensitivity or allergy to aspirin or other NSAID, and/or aspirin triad, and at least one of the following: • History of previous GI bleeding within the last 5 years • Current or recurrent gastric ulceration • History of NSAID-induced gastropathy • Currently treated for GERD Vioxx 50mg is not recommended for chronic use. Medicaid does not cover Vioxx at this dose for extended periods.

Disease-modifying anti-rheumatic drugs (DMARD)
Arava (leflunomide)
Enbrel (etanercept)
Kineret (anakinra)
Remicade (infliximab)
	• Diagnosis of rheumatoid arthritis
	• Rheumatology consult with date and copy of consult included
	• Failure with or contraindication to methotrexate alone or in combination with sulfasalazine, hydroxychloroquine or Arava, in which case Enbrel, Remicaid, or Kineret may be approved either alone in combination with Arava.
	• Kineret may be used alone or in combination with DMARD's other than tumor necrosis factor (TNF) blocking agents (i.e. Enbrel)
	  • Enbrel or Remicaid whether alone or in combination with methotrexate or Arava may be approved for first-line treatment in patients with moderately to severely active rheumatoid arthritis as evidenced by:
	  • > 10 swollen joints
	  • $\geq$ 12 tender joints
	  • Elevated serum rheumatoid factor levels or erosions on baseline x-rays

Remicade (infliximab)	Diagnosis of: • Moderately to severely active Crohn's disease for patients with an inadequate response to conventional therapy • Fistulizing Crohn's disease
Ambien (zolpidem) Sonata (zaleplon) Quantity limited to 90 tablets per year.	Trial and failure with at least <u>two</u> multi-source prescription sleep-inducing drugs.
Viagra (sildenafil) Quantity limited to seven (7) tablets per month	• Diagnosis of erectile dysfunction. • Males only, 18 years of age or older. • No concomitant organic nitrate therapy.

PA Criteria for Prescription Drugs (continued)

Drug	Criteria
Thalomid (thalomide)	Treatment of the cutaneous manifestations of moderate-to-severe erythema nodosum leprosum (ENL). Considered for other diagnoses on individual basis.
Zyvox (linezolid)	Adult patients with vancomycin-resistant enterococcus.
Zoloft 25 mg & 50 mg (sertraline)	Authorized for patients needing dosages requiring 25 mg or 50 mg tablets (i.e., 75 mg, 125 mg).
Dipyridamole	As adjunct to warfarin anticoagulants in the prevention of postoperative thromboembolic complications of cardiac valve replacement.
Tretinoin PA required for patients 26 years and older.	Diagnose of: • Skin cancer • Lamellar ichthyosis • Darier-White disease • Psoriasis • Severe recalcitrant (nodulocystic) acne
Growth hormones	Diagnosis of: • Growth hormone deficiency in children and adults • Growth retardation of chronic renal insufficiency • Turner's Syndrome • AIDS-related wasting Children and adolescents must meet the following criteria: • Standard deviation of 2.0 or more below mean height for chronological age • No expanding intracranial lesion or tumor diagnosed by MRI • Growth rate below five centimeters per year • Bone age 14-15 years or less in females and 15-16 years or less in males • Epiphyses open **Growth hormone deficiency in children:** Failure of any two stimuli tests to raise the serum growth hormone level above 10 nanograms/milliliter. **Growth retardation of chronic renal insufficiency:** Irreversible renal insufficiency with a creatinine clearance <75 ml/min per 1.73m^2 but pre-renal transplant. **Turner's Syndrome:** Chromosomal abnormality showing Turner's syndrome. **Growth hormone deficiency in adults:** • **Adult Onset:** Patients have somatotropin deficiency syndrome (SDS) either alone or with multiple hormone deficiencies, (hypopituitarism), as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy or trauma. • **Childhood Onset:** Patients who had growth hormone deficient during childhood and now have somatotropin deficiency syndrome (SDS).

PA Criteria for Prescription Drugs (continued)

Drug	Criteria
Aggrenox (aspirin/dipyridamole)	For prevention of recurrent stroke in patients who have experienced a transient ischemic attack or previous ischemic stroke and who have failed aspirin or have a contraindication to: • Plavix (clopidogrel) or Ticlid (ticlopidine) • Coumadin (warfarin)
Gastro-intestinal drugs Includes H-2 antagonists, proton pump inhibitors, Sucralfate, and Cytotec PA required after a 90-consecutive-day course of treatment with proton pump inhibitors. PA required after 30 consecutive days with Sucralfate. Concurrent therapy requires PA. Consecutive alternating regimens of different drugs counted as part of the total 90-day period.	Diagnosis of: • Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, multiple endocrine adenomas) • Symptomatic gastroesophageal reflux (not responding or failure of maintenance therapy) • Symptomatic relapses (duodenal or gastric ulcer) on maintenance therapy • Barretts esophagus • GERD Other conditions considered on an individual basis. Sucralfate authorized for an initial 30-day concurrent therapy with histamine H2-receptor antagonists and proton pump inhibitors. Concurrent therapy for a period exceeding 30 days considered duplicate therapy and not covered. Concurrent, combination therapy of proton pump inhibitors and histamine H2-receptor antagonists regarded as duplicate therapy and not covered.
Migraine Headache Drugs For monthly quantities greater than: Imitrex (sumatriptan): 4 injections (2 kits) **or** 9 tablets **or** 6 units of nasal spray Maxalt (rizatriptan): 9 tablets for 5 mg or 10 mg tablets and 9 tablets for MLT-5 mg or MLT-10 mg Zomig (zolmitriptan) and Zomig ZMT: 9 tablets for 2.5 mg or 9 tablets for 5 mg. Migranal (dihydroergotamine): 4 units Amerge (naratriptan HCl): 9 tablets	Indicated only for treatment of <u>acute</u>, migraine/cluster headache attacks for patients who meet the following criteria: • No history of, or signs or symptoms consistent with, ischemic heart disease (angina pectoris, history of MI or documented silent ischemia) or Prinzmetal's angina • No uncontrolled hypertension • No complicated migraine including vertebrobasilar migraine • Not pregnant • No use of ergotamine-containing medication(s) within previous 24-hours • No use of MAOI within previous 2-weeks • Non-responsive to NSAIDS, acetaminophen, combination analgesics (isometheptene, butalbital, +/- metoclopramide), or ergot derivatives, or these medications are contraindicated Only one migraine medication may be prescribed within a month. Concurrent therapy with Stadol will not be covered.

PA Criteria for Prescription Drugs (continued)

Drug	Criteria
Toradoloral (ketorolac) For quantity greater than a 5-day supply within a month	Indicated for the short-term treatment of acute pain. Authorization considered on an individual basis.
Stadol (butorphanol) PA required for quantities greater than 3 - 2.5 ml metered dose spray pumps within a one-month period	Indicated for management of pain including post-operative analgesia or acute migraine headache pain for patients who meet the following criteria: • No history of hypersensitivity to butorphanol or any components of the product • No history of narcotic dependency or abuse • Not pregnant • No ulcerations of the nasal mucosa • No history of psychological or neurological disorder • No history of head trauma within the previous 7 days • 18 years of age or older • Non-responsive to NSAIDS, acetaminophen, combination analgesics (isometheptene, butalbital, +/- metoclopramide), or ergot derivatives, or these medications are contraindicated.
Weight Reduction Drugs Fastin, Ionamin (phentermine) Meridia (sibutramine) Xenical (orlistat)	Diagnosis of: • Severe obesity (BMI greater than 27) and hypertension, diabetes, hypercholesterolemia, sleep apnea, or other related co-morbid disease state; or • Severe obesity (BMI greater than 30) with no co-morbidities and enrollment in a comprehensive weight-reducing program, including at a minimum, dietary management and exercise. Significant weight loss achieved during a 4- to 6-week trial. Client's weight must be reported to the prior authorization unit monthly. Chronic therapy considered if patient maintains 10% weight loss or 5% weight loss with improvement of co-morbid health factors.
Smoking Cessation Drugs Nicotine-replacement products Zyban (buproprion)	Authorization given for 4-month course of therapy. Four trials of therapy are allowed.
Trental (pentoxifyline) Pletal (cilostazol) For greater than 12-week supply within a 12-month period.	• Diagnosis of <u>intermittent claudication</u> as the result of chronic occlusive arterial disease (COAD) of the lower limbs. Possible causes of COAD include: arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's disease), arteritis, trauma, congenital arterial narrowing, or other forms of peripheral vascular disease resulting in chronic vascular occlusion in the legs; **and** • The patient has shown clinical improvement in their COAD while on pentoxifylline or cilostazol. • Considered on an individual basis when pentoxifylline or cilostazol is being used as part of a standardized treatment protocol, e.g. bone marrow or oncology treatment protocols.

PA Criteria for MHSP Prescription Drugs	
Drug	**Criteria**
buspirone (Buspar)	• Augumentation of depression and/or obsessive compulsive disorder (OCD). • Generalized anxiety disorder.
zaleplon (Sonata) zolpidem (Ambien)	Trial and failure with at least **two** multi-source prescription sleep-inducing drugs.
amotrigine (Lamictal)	• Diagnosis of bi-polar disorder. • Intolerance, contraindication, or partial response to Lithium, Tegretol, or Depakote.
guanfacine (Tenex) isradipine (DynaCirc) levothyroxine sodium (Synthroid) liothyronine sodium (Cytomel) pindolol (Visken) propranolol HCl (Inderal) verapamil, verapamil HCl (Calan)	Use as augmentation strategy specifically related to mental health treatment.
maprotiline HCl (Ludiomil)	Considered on an individual basis.
sertraline (Zoloft 25 mg & 50 mg)	Authorized for patients needing dosages requiring 25 mg or 50 mg tablets (i.e., 75 mg, 125 mg).
gabapentin (Neurontin)	Must specify if anxiety (generalized anxiety, panic disorder, post traumatic stress disorder) and/or compelling reason with bipolar disorder.
topiramate (Topamax)	Diagnosis of bipolar disorder, obesity, intolerance, time effective of Lithium, Depakote, Trileptal/Tegretol.

Other Programs

Clients who are enrolled in the Mental Health Services Plan (MHSP) or the Children's Health Insurance Plan (CHIP) are not enrolled in PASSPORT, so the PASSPORT requirements in this chapter do not apply. However, prior authorization may be required for certain services. Refer to the *Mental Health Services Plan* manual.

For a CHIP medical manual, contact BlueCross BlueShield of Montana at (800) 447-7828 x8647. The CHIP Dental manual and additional CHIP information are available on the *Provider Information* web site (see *Key Contacts*).